### **Quality and Safety Committee**

### **Patient Safety Guideline Implementation**

**Presented to the** 

**Health Care Quality and Cost Council** 

May 16, 2012

By Paula Griswold, Executive Director,

**Massachusetts Coalition for the Prevention of Medical Errors** 



### **Today's Presentation**

- Objectives
  - Overview / History
  - Review/Approve Manual
  - Discuss Rollout Plan
    - Obtain input from Council
    - Review list of Professional Associations/Organizations



### **History**

- Developed by Quality and Safety Committee, most recently under leadership of Dr. Karen Boudreau
- Proposed as voluntary program, simple enough to carry out in any size or type of setting
- Strategy outreach through professional associations
- Input from many parties over several years:
  - MA Coalition, Betsy Lehman Center, IHI, MMS, Health Care for All, GIC, BORM, BCBSMA, DPH, and others
- Interviews with several professional associations to comment on strategy – well received
- First drafts of manual
- Rollout Plan



### **Patient Safety Guideline - text**

- Titled: "Guideline for Patient Safety Programs in All Healthcare Settings"
  - Shifting focus from a "Manual" to "Guidelines"
- NOT a mandate
- Version 1.0 intended to be a "living document"
- Present for discussion with small groups (6-8) of professional associations representatives
- Will discover different issues in more specialized or smaller settings
- Initial branding/graphics included, still in process
- Text request final approval



# **Guideline for Patient Safety Programs in All Healthcare Settings**

- Foundation of Patient Safety
  - Systems
  - Culture
- Elements of a Patient Safety Program
  - Leadership for safety
  - Point person for safety
  - Continual process improvement
  - When something goes wrong
  - Learn from patients and families
- Getting Started... then Maintaining a Program



## **Patient Safety Program - Rollout**

- Rollout Plan focused on near term to operate through Quality and Safety Committee Acting Chair and members, with HCQCC staff support
- Anticipate support from organizations on the Quality and Safety Committee who assisted in development
  - MA Coalition for Prevention of Medical Errors
  - Mass Medical Society
  - MA Board of Registration in Medicine
- Outreach/meetings with state agencies (see attached list)
- Outreach/meetings with small groups of professional associations ( see attached list)
- Consider Cover Letters of Endorsement
  - Templated with EOHHS, partner organizations CEO

# **Development and Rollout Plan through 2013**

Month	Task
Jan 2011 – April 2012	<ul> <li>Develop initial guide "Guideline for Patient Safety Program in all Healthcare Settings"</li> <li>Develop rollout process</li> <li>Define list of state agencies for outreach</li> <li>Define full list of professional organizations and associations</li> </ul>
May 16 2012	<ul> <li>Quality and Safety Committee complete draft document, present for approval</li> <li>Present rollout process for HCQCC comment</li> </ul>
May 2012 – December 2012	<ul> <li>Post document on HCQCC website</li> <li>Quality and Safety Committee engage Professional Organizations and Associations through a series of small meetings; get input for strategy</li> <li>Develop cover letter for EOHHS Secretary; with professional associations, develop draft cover letter language for endorsement</li> <li>Quality and Safety Committee collects comments, additional resources, providers update to HCQCC</li> <li>Professional Organizations and Associations begin outreach to engage their memberships</li> </ul>
January 2013- May 2013	<ul> <li>Professional organizations continue to offer education, feedback and tools to their members on best practices and lessons learned</li> <li>Professional organizations and Quality and Safety Committee, with HCQCC, develop a survey tool to be used in fall of 2013</li> </ul>
June 2013- December 2013	Quality and Safety Committee outreach to professional associations to conduct survey



# Rollout Plan - 2014 and beyond

Month	Task
January 2014 – March 2014	<ul> <li>Professional organizations report back best practices and lessons learned in aggregate to Committee.</li> <li>Results reviewed by professional organizations and committee and consideration be given to having the HCQCC post progress on its administrative website</li> </ul>
January 2014 - December 2014	<ul> <li>Professional organizations continue to offer education, feedback and tools to their members on best practices and lessons learned</li> <li>Outreach to patients/consumers about patient safety programs in all settings</li> <li>Data collection using surveys in fall 2014</li> </ul>
January 2015	Reporting in aggregate by the Professional organizations and associations to the on progress in settings based on Year 1 of the survey data
March 2015	Review of results and consideration by the committee and professional organizations regarding HCQCC posting progress on its administrative website



## **Questions / Discussion**

- Approve Text
- Discussion on Rollout

